



## **Driver Training Instructor Checklist**

***PLEASE READ CAREFULLY, AS THE APPLICATION HAS BEEN RECENTLY REVISED***

- ☐ All applicants must sign the Statement of Completion at the bottom of this page and include with the application.
- ☐ All applicants must complete all sections of the application.
- ☐ Submit an application fee of \$5.00, in the form of a money order, certified check, or cashier's check, made payable to Georgia Department of Driver Services.
- ☐ Submit an examination fee of \$25.00, in the form of a money order, certified check, or cashier's check, made payable to the Georgia Department of Driver Services. Neither fee nor examination are required if applicant submits a valid Georgia teaching certificate reflecting certification in Safety and Driver Education. Certificate must be valid. If you do not have such certificate, an examination fee of \$25.00 is required.
- ☐ All applicants must undergo a fingerprint-based background check as designated by the Department of Driver Services. Instructions will be forthcoming after the application is received.
- ☐ All applicants must submit a notarized Consent for Background Investigation. (Form # RC-900)
- ☐ Submit a photograph taken within 30 days of application submission.
- ☐ Submit a lab report, from an accredited lab, showing the results for drug screen taken within 30 days of filing the application. The lab report for the drug screening must include the results for the following substances: amphetamines, cocaine metabolites, marijuana metabolites, opiates, and phencyclidine.
- ☐ Submit a Physical Examination Form completed and signed by your doctor within 30 days of filing application. (Form # RC-DT-201)
- ☐ Submit a notarized statement from the owner of the driver training school that the applicant is or will be employed by the school.
- ☐ If you have been licensed in a state (or states) other than Georgia in the past five (5) years, you must obtain and submit a Motor Vehicle Report (MVR) from each state in which you were licensed.

### **STATEMENT OF COMPLETION**

I hereby certify that this application includes all documents and fees which are required to be attached, for the approval as outlined above. I understand that an incomplete application or application lacking the necessary paperwork will result in my application not being processed and may result in fees being forfeited.

### **STATEMENT OF ACKNOWLEDGEMENT**

I understand that I will be notified of training dates and location after my application has been accepted. Training is offered at the DDS Headquarters in Conyers on the 2<sup>nd</sup> and 4<sup>th</sup> Thursday of every month. Reservations for training classes are required prior to each class.

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Printed Name

Legal Signature

Date

Please submit application, fees and all supporting documents to:  
Georgia Department of Driver Services  
Attn: Regulatory Compliance Division  
2206 East View Parkway  
Conyers, Georgia 30013

An application drop box is also available at the entrance of the Conyers Customer Service Center.



## **Driver Training Instructor Application**

### **SECTION 1: School Information**

**1.1** Indicate, in the space provided below, the full name of the driver training school where you will be employed.

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### **SECTION 2: Applicant Information**

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Last Name	First Name	Middle Name	Suffix
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Date of Birth	Driver's License #	State of Issuance	Social Security #
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Home Address	City	State	County	Zip Code
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Mailing Address	<input type="checkbox"/> Same as above	City	State	County	Zip Code
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Home Phone Number	Cell Phone Number	Work Phone Number
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Email Address

☐ **I would prefer all correspondence be mailed to the address above.**  
**Note: Unless the box is checked, all correspondence will be emailed.**

**2.1** Have you been fingerprinted within the past six (6) months for any other DDS Program (i.e. risk reduction, driver improvement)?  
☐ Yes ☐ No

**2.1.1** If you answered "Yes" to question 2.1, indicate in the space provided below the program(s) for which you were fingerprinted and the date(s).

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Program(s)

Date(s)

**2.2** Are you currently, or have you ever been, certified as a driver training school owner or instructor in the state of Georgia?  
☐ Yes ☐ No

**2.2.1** If you answered "Yes" to question 2.2, list your certification number: \_\_\_\_\_

**2.3** Are you currently, or have you ever been, certified by the Department of Driver Services as a risk reduction or driver improvement owner or instructor, or an ignition interlock operator, or an alcohol and drug awareness (ADAP) instructor?  
☐ Yes ☐ No

**2.3.1** If you answered "Yes" to question 2.3, indicate your certification type(s) and certification number(s):

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### **SECTION 3: Applicant Qualifications**

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**3.1** Are you a United States citizen?

☐ Yes ☐ No

**3.1.1** If you answered "No" to question 3.1, are you legally present in the United States?

☐ Yes ☐ No

**NOTE:** *Acceptable proof of citizenship or lawful presence may be required.*

**3.2** Are you currently employed with the Georgia Department of Driver Services?

☐ Yes ☐ No

**3.3** Do you have a spouse, dependent child, dependent stepchild, or dependent adopted child that is currently employed with the Georgia Department of Driver Services

☐ Yes ☐ No

**3.4** Are you at least 21 years of age?

☐ Yes ☐ No

### **SECTION 4: Criminal History**

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**4.1** Have you ever been convicted of or plead guilty or *nolo contendere* to any crime which constitutes a felony?

☐ Yes ☐ No

**4.2** Have you been convicted of or plead guilty or *nolo contendere* to any misdemeanor involving fraud, dishonesty, or deceit within the ten (10) year period preceding the date of this application?

☐ Yes ☐ No

**4.3** Have you been convicted of or plead guilty or *nolo contendere* to any other misdemeanor, including driving under the influence, within the five (5) year period preceding the date of this application?

☐ Yes ☐ No

**4.4** Are you currently on probation for any criminal offense in this or any other state?

☐ Yes ☐ No

**4.4.1** If you answered "Yes" to question 4.4, give the nature of probation in the area below.

Offense	State and County	Date
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Offense	State and County	Date
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**4.5** Are there any criminal charges currently pending against you?

☐ Yes ☐ No

**4.5.1** If you answered "Yes" to question 4.5, provide the nature of the charges below.

Charge	State and County	Date
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Charge	State and County	Date
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4.6 In the space provided below, list your complete criminal history for the previous ten (10) years, including charges that were dismissed, *nolle prossed*, or no-billed.

Offense	State and County	Date	Disposition
Offense	State and County	Date	Disposition
Offense	State and County	Date	Disposition
Offense	State and County	Date	Disposition

4.7 Have you received a pardon for any of the offenses listed in question 4.6 above?  
☐ Yes ☐ No

4.7.1 If you answered “Yes” to question 4.7, attach a copy of the pardon.

**SECTION 5: Driving History**

5.1 Do you currently possess a valid driver’s license?  
☐ Yes ☐ No

5.2 In the area provided below, list your driver’s license information for the past five (5) years, including any previous states.

Driver’s License Number	State	Expiration Date	Years Licensed in State

5.3 Is your driver’s license or driving privileges currently cancelled, suspended, or revoked in this state or any other jurisdiction?  
☐ Yes ☐ No

5.4 Are there any *pending* cancellations, suspensions, or revocations against your driver’s license?  
☐ Yes ☐ No

5.5 Has your driver’s license been cancelled, suspended, or revoked within the past five (5) years?  
☐ Yes ☐ No

5.5.1 If you answered “Yes” to question 5.5, list the state(s) that revoked, suspended, cancelled, or denied your driver’s license and the reason(s).

State	Reason	Month/Year



5.6 List your complete driver’s history for the previous five (5) years, including pleas of *nolo contendere*.

Offense	State and County	Date	Disposition
Offense	State and County	Date	Disposition
Offense	State and County	Date	Disposition
Offense	State and County	Date	Disposition

5.7 Are there any traffic charges currently pending against you?  
☐ Yes ☐ No

5.7.1 If you answered “Yes” to question 5.7, provide the nature of the charges below.

Charge	State and County	Date
Charge	State and County	Date

**SECTION 6: Applicant Affirmation**

Under penalty of law, I do hereby swear or affirm that all the information that I have provided herein is complete and accurate.

I will refrain from abusing alcohol or other drugs, and from using illegal drugs.

I will maintain all reports and information as specified in the DDS rules and regulations.

I hereby authorize the release to DDS of any information necessary for the determination of my application for instructor certification. I understand that this information will be used only for the purpose of processing my application. Photocopies of this authorization will be valid for the purpose of obtaining requested information.

*I understand that to knowingly make a false statement or conceal a material fact in this application will result in the denial of my application, the cancellation of my certification (if applicable), and criminal charges being brought against me.*

Legal Signature	Date
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Sworn to and subscribed before me

this \_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_.

(SEAL)

\_\_\_\_\_  
Notary

**Georgia Department of Driver Services**  
**Regulatory Compliance Division, 2206 East View Parkway, Conyers, GA 30013**

**CONSENT FOR BACKGROUND INVESTIGATION**

OFFICE USE ONLY FILE NUMBER:	OFFICE USE ONLY DATE APPLICATION RECEIVED:	OFFICE USE ONLY BACKGROUND <input type="checkbox"/> DRIVER'S HIST P F <input type="checkbox"/> CRIMINAL HIST P F	OFFICE USE ONLY
OFFICE USE ONLY			

**APPLICANT TYPE: (OFFICE USE ONLY)**

<input type="checkbox"/> DUI Risk Reduction	<input type="checkbox"/> Owner	<input type="checkbox"/> Director	<input type="checkbox"/> Instructor
<input type="checkbox"/> Driver Improvement	<input type="checkbox"/> Owner	<input type="checkbox"/> Instructor	
<input type="checkbox"/> Driver Training	<input type="checkbox"/> Owner	<input type="checkbox"/> Instructor	
<input type="checkbox"/> Third Party	<input type="checkbox"/> Tester	<input type="checkbox"/> Examiner	
<input type="checkbox"/> Ignition Interlock	<input type="checkbox"/> Owner/Operator		
<input type="checkbox"/> Chauffeur			

Last Name	First Name	Middle	Date of Birth (MM/DD/YYYY)  / /
Driver's License Number (Include ALL zeros)	Issue date (Exam date)	State	Social Security Number
Current Street Address		City and State	Zip Code
Do you hold any other driver's license(s)?  Yes      No	If so, list state(s) and license number(s)		Phone Number
Company			Phone Number
Address		City and State	Zip Code

Have you been convicted of, plead guilty to, plead nolo contendere to, served time, or been on probation or parole for any crime whether felony or misdemeanor, in this state, in any other state, or in the federal system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a charge(s) or court hearing pending, or are you under indictment or accusation for any crime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you are now charged, under indictment, or have court hearings pending for any charges, give details below:	

**I hereby apply for Certification(s) to be issued by the Regulatory Compliance Division of the Department of Driver Services (DDS). I understand that my criminal history, driver's history, and legal presence will be checked. I hereby give consent for the DDS to conduct whatever investigations necessary to determine my eligibility to hold such a certificate. I understand that false, misleading, or incomplete information in my application or on this Consent Form may result in certificate denial, cancellation, suspension, or revocation, as well as possible criminal prosecution and civil action. Under penalty of perjury, I do hereby swear or affirm that the information contained within this application, and any statements made in connection therewith, are complete, true and correct.**

Signature

Date

**THIS CONSENT FORM MUST BE NOTARIZED**

Subscribed to and sworn before me:

SEAL OR STAMP

Notary Signature

Date

My commission expires:

# PHYSICAL EXAMINATION FORM

A separate copy of an official laboratory report for a drug screening must be attached to this Physical Examination Form. Drug screen should include, as a minimum: amphetamines, cocaine metabolites, marijuana metabolites, opiates, and phencyclidine. Physical and drug screen must be administered within thirty (30) days of filing application.

Name: \_\_\_\_\_  
(First) (Middle) (Last)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Date of Birth: \_\_\_\_\_  
(Month) (Day) (Year)

## Health History

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Any illness or injury in last 5 years	<input type="checkbox"/>	<input type="checkbox"/>	Eye disorders or impaired vision (except corrective lenses)
<input type="checkbox"/>	<input type="checkbox"/>	Head/Brain injuries, disorders or illnesses	<input type="checkbox"/>	<input type="checkbox"/>	Ear disorders, loss of hearing or balance
<input type="checkbox"/>	<input type="checkbox"/>	Seizures, epilepsy Medication _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or heart attack; other cardiovascular condition Medication _____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure Medication _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)
<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease	<input type="checkbox"/>	<input type="checkbox"/>	Fainting, dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Stroke or paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease, emphysema, asthma, chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Spinal injury or disease
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease, dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Chronic low back pain
<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Regular, frequent alcohol use
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or elevated blood sugar controlled by: <input type="checkbox"/> Diet <input type="checkbox"/> Pills <input type="checkbox"/> Insulin	<input type="checkbox"/>	<input type="checkbox"/>	Nervous or psychiatric disorders e.g., severe depression Medication _____

Other illness or injuries: \_\_\_\_\_

## Physical Information

General appearance and development: ☐ Good ☐ Fair ☐ Poor

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Eyes for Distance (without glasses/contacts): Right 20 / \_\_\_\_\_ Left 20 / \_\_\_\_\_

Eyes for Distance (with glasses/contacts): Right 20 / \_\_\_\_\_ Left 20 / \_\_\_\_\_

Evidence of eye injury: Right: \_\_\_\_\_ Left: \_\_\_\_\_

Color Vision: \_\_\_\_\_ Horizontal Field: Right: \_\_\_\_\_ Left: \_\_\_\_\_

Ears (Hearing @ 20 ft.): Right: \_\_\_\_\_ Left: \_\_\_\_\_

<u>Yes</u>	<u>No</u>	<u>Body System:</u>	<u>Check For:</u>
<input type="checkbox"/>	<input type="checkbox"/>	General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.
<input type="checkbox"/>	<input type="checkbox"/>	Eyes	Papillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos, strabismus uncorrected by corrective lenses, retinopathy, cataracts, aphakia, glaucoma, macular degeneration.
<input type="checkbox"/>	<input type="checkbox"/>	Ears	Middle ear disease, occlusion of external canal, perforated eardrums.
<input type="checkbox"/>	<input type="checkbox"/>	Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Heart	Murmurs, extra sounds, enlarged heart, pacemaker.
<input type="checkbox"/>	<input type="checkbox"/>	Lungs and chest, not breast examination	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, dyspnea, cyanosis. Abnormal finding on physical exam may require further testing such as pulmonary tests and/or x-ray of chest.
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruising, hernia, significant abdominal wall muscle weakness.
<input type="checkbox"/>	<input type="checkbox"/>	Vascular System	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.
<input type="checkbox"/>	<input type="checkbox"/>	Genito-urinary system	Hernias.
<input type="checkbox"/>	<input type="checkbox"/>	Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.
<input type="checkbox"/>	<input type="checkbox"/>	Neurological	Impaired equilibrium, coordination or speech pattern; paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.
<input type="checkbox"/>	<input type="checkbox"/>	Extremities – Limb Impaired	Loss or impairment of leg, foot, toe, arm, hand, finger. Perceptible limb deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly.

Comments: \_\_\_\_\_

### Laboratory Findings:

Urine: Spec. Gr.: \_\_\_\_\_ Protein: \_\_\_\_\_ Sugar: \_\_\_\_\_

Blood Pressure (Sitting): Systolic: \_\_\_\_\_ Diastolic: \_\_\_\_\_

Pulse: Before Exercise: \_\_\_\_\_ Two Minutes After Exercise: \_\_\_\_\_

**Instructor's Statement:** I affirm that I have answered all medical questions honestly and to the best of my knowledge.

\_\_\_\_\_  
Signature of Driver Training Instructor

\_\_\_\_\_  
Date

### Doctor's Statement:

I affirm I have examined \_\_\_\_\_ on \_\_\_\_\_ (date)

and find his or her physical condition sufficiently sound to perform the duties required of a Driver Training Instructor.

\_\_\_\_\_  
Printed Name of Examining Doctor

\_\_\_\_\_  
Street Address of Examining Doctor

\_\_\_\_\_  
Signature of Examining Doctor

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Doctor or Facility Telephone No.: \_\_\_\_\_